WIC HEALTH QUESTIONNAIRE Pregnant Woman

Date:___

	Woman's Name B	irth Date	Due	e Date	
			Circle Yes or No		NRFs
1.	Have you been pregnant before? (If no, skip to question following): How many times have you been pregnant (including this tim Date of last delivery, miscarriage or abortion: How many children do you have?	e)?	No	Yes	System Assigned NRFs
2.	Before you became pregnant (this pregnancy) how much	· •	İ		
3.	Do you now receive prenatal care from a doctor or clinic In which month of pregnancy did care begin?Name of doctor/clinic:	?	Yes	No	Refer
4.	In the 3 months before pregnancy, how many cigarettes cigarettes or packs How many cigarettes do you now smoke each day? Have you quit smoking since you became pregnant? Does anyone else living in your household smoke inside the		Yes No	No Yes	ES
5.	Have any of your friends or family had drinking or drug p	problems?	No	Yes	
6.	In the 3 months before pregnancy, how often did you dr or mixed drinks? days each week	□ Never			System
					Assigned NRFs/
7.	In the three months before pregnancy did you use any of Medicine (doctor prescribed) □ Over-the-counter drugs (a Vitamin/mineral pills (other than prenatal ones) □ Alcoh Methamphetamine □ Cocaine □ Spee Heroin □ LSD □ Valium Other:	spirin, cold tablets, diet pills)□ ol □ Mariiuana □	No	Yes	Counsel/ Refer
	If yes, how often (once, daily, weekly, monthly)? Do you now use any of those drugs? If yes, how often? Which ones?	<u> </u>	No	Yes	
8.	Have you had a blood lead test done in the last 12 month	ns?	No	Yes	
9.	Have you thought about breastfeeding this baby?		Yes	No	
10.	Have you ever breastfed a baby?		Yes No	No Yes	Counsel/ Refer
11.	Have you ever been checked for flat or inverted nipples?		Yes	No	
12.	With any past pregnancy, did you have any of the follow Pregnancy-related diabetes (problems with blood sugar) ☐ Infant born more than 3 weeks early ☐ Infant birth weight Death of fetus or infant less than one month old ☐ Infant born with neural tube defect or cleft lip or palate ☐ Preceipments ☐	_	No	Yes	Previous Pregnancy

13.	Severe nausea or vomiting (Hyperemesis Gravidarum) Pregnancy-related diabetes (problems with blood sugar) A twin or triplet pregnancy Hypertension or Prehypertension		Yes	79 80 83
14.	4. Do you currently have a medical problem diagnosed by a doctor (such as diabetes, high blood pressure, hepatitis, HIV/AIDS, eating disorder or food allergy)? If yes, describe:			Medical
15.	5. Do you have a chronic dental problem such as severe decay, tooth loss, periodontal disease or gingivitis that affects your food intake?		Yes	Conditions
16.	6. Have you had major surgery in the last two months?		Yes	
17.	/. Are you currently breastfeeding an infant or child?		Yes	66
18.	Are you now in foster care? If yes, when did you move to this foster care home?		Yes	94
19.	How much weight do you expect to gain while pregnant?			
20.	0. Are you having any of the following?			
	Gas □ Heartburn □ Constipation □ Diarrhea □ Vomiting □			
21.	How to breastfeed ☐ Fitting breastfeeding into your life ☐ Fitting breastfeeding into your life ☐ Having good milk ☐ Working/going to school & breastfeeding ☐ Pumping your breasts ☐ Weight gain ☐ Sore nipples ☐ Finding a doctor for your baby ☐ Breastfeeding in public ☐ Child support payments ☐ Drinking while pregnant ☐ Family planning/birth control ☐ Smoking while pregnant ☐ Using drugs while pregnant ☐ Other: ☐ Using drugs while pregnant ☐ Other: ☐ Fitting breastfeeding into your life ☐ Having enough milk ☐ Working/going to school & breastfeeding ☐ Finding a doctor for your baby ☐ Child support payments ☐ Family planning/birth control ☐ Using drugs while pregnant ☐ Using drugs while pregnant ☐ Other: ☐ Othere			Counsel/ Refer
	Would you like information about: Medicaid □ TANF □ Food Stamps □	No	Yes	
22.	2. Do you now receive regular dental care?			
23.	How often do you exercise, such as walking for 20-30 minutes without stopping? What kind of exercise?			
Que	estionnaire assessed by:			(staff

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